April 7, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0807-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___, a 50-year-old gentleman, injured his lower back on ___ while he was employed for the ___. The injury was described as a repetitive bending and repetitive straining injury while lifting heavy cases of soft drinks. He noted pain in his lower back, with some radiation of pain into his legs.

He was worked-up and treated for this injury. He had an MRI on December 1, 1993 that showed a small central midline disc protrusion at L4/5 and also at L5/S1. There was no apparent nerve root compression reported on this MRI. The patient had an EMG done on his lower extremities on September 3, 1993 that was reported to be entirely normal. He was felt to be having symptoms from degenerative lumbar disc disease in his lumbar spine. These degenerative changes were documented with the MRI that was done on the aforementioned MRI. The patient's diagnosis was lumbar strain without evidence of myeloopathy, radiculopathy or neuropathy. He was referred to ___, a spine surgeon, who recommended lumbar epidural steroid injections that were provide by ___. The injections did provide some relief. A Designated Doctor then determined him to be at MMI on June 27, 1994, awarding him a 14% impairment rating. There are no medical records provided from that date in 1994 until September 18, 2002. At that time, on September 18, 2002, the patient saw ___ who recommended that he get another lumbar MRI.

REQUESTED SERVICE

A repeat lumbar MRI is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The previous 1993 MRI demonstrated degenerative changes in the back, non-compressive disc herniations at L4/5 and L5/S1. Given this patient's history, the ___ reviewer cannot disagree with obtaining an MRI to evaluate this patient's present complaints of back pain. The MRI should be done to evaluate the present status of this gentleman's lower back.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 9th day of April 2003.